ASK PEDIATRICS
1215 Lee Ave.
Tallahassee, Florida 32303
Tel: (850) 878-00229 Fax: (850) 942-5837
Aisha D. Bailey, D.O.

Patient's First Name:	Age:	Sex:	DOB:
Patient's Last Name:		Home Phone Number:	Mobile Phone Number:
Home Street Address:		City/State:	Zip Code:

Primary Contact/Guardian Information

First Name:	Relation to Patient:	S.S.#:	
Last Name:	DOB:	Primary Language:	
Home Street Address:	City/State:		Zip code:
Home Phone Number:	Mobile Phone Number:	Work Phone Number:	
Email Address:	Preferred Contact Method (please circle): Home Mobile Work Email		

Secondary Contact/Guardian Information

First Name:	Relation to Patient:	S.S.#:	
Last Name:	D.O.B:	Primary Language:	
Home Street Address:	City/State:	Zip code:	
Home Phone Number:	Mobile Phone Number:	Work Phone Number:	
Email Address:	Preferred Contact Method (please circle): Home Mobile Work Email		

Emergency Contact (other than parents)

Full Name:	Relation to Patient:	Contact Number:

Please list any additional people authorized to accompany the patient to appointments and consent to medical care

Full Name:	Relation to Patient:	Contact Number:
Full Name:	Relation to Patient:	Contact Number:

Authorization to pay benefits: I hereby authorize payment directly to Aisha D. Bailey, D.O. for any procedures including surgical, medical, physicals, and immunizations. I understand that if I am not eligible under the terms of my health plan agreement, or if for any reason the insurance company does not pay, that I am liable for all services rendered. I also understand that I am liable for fees incurred for missed appointments.

Primary Insured: _____

Authorization for Medical Care (Signature):X_____

Insurance Company: _____ Insurance Policy Number:_____

.

Group Number: _____

PATIENT NAME _____
D.O.B. _____

PEDIATRIC HISTORY FORM

When was your child's last physical exam? _____
Where? _____

BIRTH HISTORY

Yes No

☐ ☐ Did you receive prenatal care? Where?
Started care at _____ month.

☐ ☐ Was the baby full term? Birth weight?
Vaginal Delivery ☐ C-section ☐ Why? _____

☐ ☐ Did the baby go home with you from the hospital? If no, why not?
Hospital where the baby was born: _____

MEDICAL HISTORY

Yes No

☐ ☐ Has your child ever been hospitalized overnight or had any previous surgeries?
If yes, when, where, why? _____
_____
_____

☐ ☐ Is your child followed by a specialist
If so, for what condition? _____

☐ ☐ Does your child take any medications on a regular basis, including vitamins?
Please list: _____

☐ ☐ Is your child allergic to any medication? _____
What happens when your child takes this medicine? _____

☐ ☐ Are your child's shots up to date?

☐ ☐ Has your child ever had a reaction to an immunization?
What happened? _____

☐ ☐ Does your child have any food allergies? _____
What happens? _____

☐ ☐ Has your child ever had a positive TB test?
When? _____ Did he/she receive a chest x-ray? _____

☐ ☐ Has your child ever had any blood work or special tests done?

☐ ☐ Has your child ever had:
UTI? Date: _____/_____/_____ Medicine taken: _____
Asthma/Wheezing? Date: _____/_____/_____ Medicine taken: _____

☐ ☐ Does your child have frequent ear infections?

☐ ☐ Does your child have any medical problems? (Such as asthma, seasonal allergies, eczema, ADHD, seizures, etc.) _____

FOR FEMALE PATIENT'S ONLY

Yes No

☐ ☐ Have you started your periods? What age? _____

☐ ☐ Are they regular? They last _____ days
LMP: _____/_____/_____

☐ ☐ Cramps? Treatment for cramps _____

Comments: _____
_____

FAMILY MEDICAL HISTORY

	Has anyone in your child's family had any of these conditions?	Father	Paternal GF	Paternal GM	Mother	Maternal GF	Maternal GM	Brother	Sister	Paternal Aunt	Maternal Aunt	Paternal Uncle	Maternal Uncle	Other
1.	Alcohol Abuse													
2.	Anemia (V18.2)													
3.	Asthma (V17.5)													
4.	Autistic Disorder													
5.	Born with Congenital Abnormalities													
6.	Cancer													
7.	Cystic Fibrosis (V18.19)													
8.	Delayed Developmental Milestones													
9.	Depression													
10.	Diabetes Mellitus (V18.0)													
11.	Drug Dependence													
12.	Eczema													
13.	Heart Disease (V17.49)													
14.	Hepatitis													
15.	Hypercholesterolemia													
16.	Hypertension (V17.49)													
17.	Juvenile Rheumatoid Arthritis/ Autoimmune issues													
18.	Migraine Headache													
19.	No Significant Family History													
20.	Reported family history of Allergies													
21.	Reported family history of Bleeding Problems													
22.	Reported family history of Deafness before age 5													
23.	Reported family history of Early Sudden Deaths													
24.	Reported family history of Kidney Disease													
25.	Reported family history of Mental Illness (not retardation)													
26.	Seizure Disorder (V17.2)													
27.	Sudden Infant Death Syndrome													
28.	Thyroid Disorder (V18.19)													
29.	Tuberculosis													
30.	Gastrointestinal Issues (such as IBD)													

SOCIAL HISTORY

☐ Adopted ☐ Foster Child

Composition of Household – Brothers:

Name Child 1: _____ DOB: _____ Age: _____

Name Child 2: _____ DOB: _____ Age: _____

Composition of Household – Sisters:

Name Child 1: _____ DOB: _____ Age: _____

Name Child 2: _____ DOB: _____ Age: _____

Guns in Home? ☐ Yes ☐ No

Guardians are: ☐ Currently Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Single ☐ Other

Guardian's Occupation: _____ Guardian's Occupation: _____

Guardian's Signature _____ Date: _____/_____/_____

Pediatric Services

1215 Lee Avenue
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(850) 878-0229

CONSENT, DISCLOSURE, AND AUTHORIZATION FORM

Patient Name: _____Medical Record #: _____
Address: _____DOB: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize ASK Pediatric Services and all physicians and ancillary medical personnel of ASK Pediatric Services, to perform medical examinations and provide routine medical care for all my visits to ASK Pediatric Services. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ASK Pediatric Services. Any photographs or other images taken will become part of my medical record. ASK Pediatric Services will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ASK Pediatric Services will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand ASK Pediatric Services' HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that ASK Pediatric Services has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, ASK Pediatric Services will post a new notice in the office. I may contact ASK Pediatric Services at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize ASK Pediatric Services to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of ASK Pediatric Services. I understand that, for example, my health information may be used or disclosed by ASK Pediatric Services to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by ASK Pediatric Services; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand ASK Pediatric Services may release my protected health information as required by law or court order.

Patient Name: _____DOB: _____

Disclosures to Authorized Individuals

I understand that ASK Pediatric Services may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____
Address/Phone: _____
Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____ _Relationship: _____
Address/Phone: _____
Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____ Relationship: _____
Address/Phone: _____
Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Name: _____ Relationship: _____
Address/Phone: _____
Health Info: Yes/No [circle as applicable] Payment Info: Yes/No [circle as applicable]

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

□ Home Telephone □ Detailed Message □ Call Back Message Only
(h) _____

□ Work Telephone □ Detailed Message □ Call Back Message Only
(w) _____

□ Cell Telephone/Text □ Detailed Message □ Call Back Message Only □ Survey
(c) _____

□ Mail to Home Address (below) □ Mail to Work Address (below) □ E-Mail (below)
Mailing address: _____
E-Mail address: _____

I understand that if I have checked the box "detailed message," I agree that ASK Pediatric Services may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, requests for responses via survey, and any other information regarding care/treatment.

Use of Consent and Authorization

A copy of this consent and authorization may be used in place of the original.

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent, and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____
Patient Signature: _____
Authorized Individual (Parent/Guardian) Name: _____
Authorized Individual Signature: _____
Basis of Authority (e.g., parent, guardian): _____

Pediatric Services

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Notice of Privacy Practices

This notice describes how medical information about your child /you may be used and disclosed and how a parent or guardian or you can access this information.

Please Read This Information Carefully!

Our Pledge Regarding Medical Information

Keeping your medical information private is important to us and we are committed to protecting it. We create and maintain a medical record on your child/you to assist in providing quality care and so that information is available day-too-day concerning current medical issues and overtime for review when needed and to comply with legal requirements.

This notice describes how we may use your child's/your medical information. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. These practices will be followed by the entire office staff as well as those consulted or used for medical coverage.

How we may use and disclose health information about you and your child

This section described ways that we may use and disclose medical information.

For Treatment

We use medical information to provide medical care. Medical information may be disclosed to physicians, nurses, technicians, medical, nursing, or health allied students, pharmacists, program personnel such as Children's Medical Services and Early Intervention Program, or other programs involved in your child's/your medical care. We may choose not to disclose certain medical information to students if it is felt that the information should be withheld. We may also share medical information with other medical practices when your child has been/you have been referred for care that is not provided at this office. Immunization information is shared without written consent to physicians to whom your child's care / your care has been transferred: schools, health departments, and agencies such as Children and Families, programs such as WIC, Children's Medical Services, or any other program involved in your child's / your care. When medical information is shared with a consulting physician to whom your child has been /you have been referred to for your medical care written consent is not necessary.

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Notice of Privacy Practices

For Payment

We may use and disclose medical information for payment purposes. Your signed authorization is maintained in the chart.

Research

No names or medical information will be provided to any group for research purposes without a witnessed or verbal signed consent.

Government Functions

Information may be shared with agencies gathering information and outcome such as immunization compliance or tracking, adverse drug reactions, product recalls, or product tracking.

Public Health Activities

We may disclose medical information to public health and associated agencies when disease prevention or control is the issue.

Victims of Abuse or Neglect or Domestic Violence

Medical information will be disclosed to the appropriate authorities if there is evidence of abuse or neglect or domestic violence.

Court Order and Judicial and Administrative Proceedings

We may disclose some medical information in response to a court and administrative order, subpoena, discovery request or other lawful processes if we are legally required to provide this information whether the parent or guardian or you have consented to not.

Law Enforcement/Child Detention

When necessary, we will share information if such is needed to ensure medical treatment of an illness when a child is being detained.

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Notice of Privacy Practices

Coroner, Medical Examiner, Funeral Directors

We may share information with these professionals if needed to assist them in carrying out their duties.

Disaster Relief

Medical information may be shared with persons or organizations assisting in disaster relief and where medical concerns are important.

Health Oversight

We may share medical information with groups, organizations, or agencies engaged in health oversight activities authorized by law, such as audits, inspections, and licensure, or disciplinary actions. We may also share information with HMO personnel who perform periodic chart reviews for compliance issues of standard of care issues.

Others

Unless you object, we will remind you by phone of your child's or your checkup. If information is to be sent to insurance companies, lawyers, social security administration or if records are being sent to a physician for transfer of care, a signed consent is required. In fact, a signed release is required in most instances other than for constitutions, information and other situations in which there is a legal requirement or a true emergency.

Other Office Practices

- If you indicate the reason of your visit on a form, please give it to someone in the front office. Do not leave it on the counter.
- Charts will be placed on the doors with the names turned towards the door.
- No decision concerning any patient or related matters is to take place when the conversation can be heard by anyone not employed by the office.
- Any privacy information on computer screens will be kept away from the view of non-office persons.
- All paper material related to patients that is to be discarded is to be shredded prior to discarding.

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Notice of Privacy Practices

Your Rights Regarding Your Child's or Your Health Information

You have the right:

- To read and receive a copy of your child's health information. You must sign a request for medical records if you are transferring care from this practice. One copy of medical records is provided free of charge—this may be copy that parent or you take or one sent to another medical office. Any subsequent copies requested from physicians will be charged at $.20 per sheet.
- To receive a list of all the timed your child has been seen at this office and all the times medical information has been shared for whatever reason.
- To amend information in the medical record that is incomplete or incorrect. The information must be kept by this office. We may deny your request if we believe that your information you with to amend is inappropriate for your medical records.
- To request restriction. You have the right to request restrictions or limits on the health information we disclose about your child/ you to someone who is involved in your child's /your care, payment parties, or family members. You may provide a list of persons to whom medical information can be provided. We are not required o comply with your request if we feel that it is not in the best interest of your child.
- To request confidential communication, for instance, you may request that you be contacted at work only.
- To request a copy of this notice.

Changes to the Notice

We reserve the right to change and revise this notice. The effective date will be listed on the changed notice.

Aisha D. Bailey, DO
1215 Lee Avenue
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(850) 878-0229

HIPAA Acknowledgement
Notice of Privacy Practices

Printed Name of Patient: _____

Patient Date of Birth: _____

I acknowledge receipt of ASK Pediatrics' Notice of Privacy Practices.

Signature of Patient/Legal Representative: _____
Date: _____

****

Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____
_____
_____

Signature of ASK Pediatrics Representative: _____
Printed Name: _____
Date: _____

ASK Pediatric Services

Aisha D. Bailey, DO
1215 Lee Avenue
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Cancellation and No-Show Policy

ASK Pediatric Services understands that there are times when you must miss an appointment due to an emergency or unforeseen obligation for work or family. However, when you do not call to cancel, missed appointments result in our not being able to schedule other children who need appointments.

We need your help in providing the highest quality and most efficient care possible for all of our children.

Please notify the office as soon as possible if you are unable to keep any scheduled appointment. **Any appointment that is not canceled one business day prior to the scheduled appointment time will be considered a no-show.** There will be a **$25 fee** for all no-shows and last minute cancellations. This fee is not billable to insurance and must be paid in full prior to scheduling any further routine appointments.

There is a voicemail box for rescheduling and/or cancelling appointments that can be accessed through ASK Pediatric Services' main phone line (850)878-0229. This mailbox timestamps all messages and is monitored throughout the day. Please leave us a voicemail if you are unable to reach a person.

Please note that excessive missed appointments may result in dismissal from the practice.

Thank you in advance for your cooperation!

_ _ _ _ _ _ _ _ _ _ _ _ _ _

I have read the above policy and understand that I will pay ASK Pediatric Services the sum of $25 in the event that I fail to cancel or reschedule any appointment at least one business day prior to my scheduled appointment time.

Signature of Parent or Legal Representative: _____
Date: _____
Printed Name of Parent or Legal Representative: _____
Name of Patient(s): _____